

Waycross College
Office of Registrar
2001 South Georgia Parkway, Waycross, GA 31503
Phone 912-449-7600 Fax 912-449-7610

Transcript Request Form

Official Transcript _____ Unofficial Transcript _____ Date: _____

Last Name: _____ First Name: _____ Maiden Name: _____

Name you attended under if changed: _____ Email: _____

Year(s) attended: _____ through _____ Student ID No: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: (Home) _____ (Work) _____

Number of copies requested: _____ I will pick up my transcript(s) _____

I request my transcript(s) faxed to: (Fax Number) _____

*Please note: Only unofficial transcripts can be faxed.

I request my transcript(s) mailed to: (Address)

Name: _____ Business: _____

College: _____ Other: _____

Attn: _____

Address: _____ City: _____

State: _____ Zip: _____

By my signature on this form, I am requesting the Office of the Registrar to furnish the above information to the recipient listed. Please submit the \$2.00 fee for each transcript requested to Student Records, payable to Waycross College. Transcripts will not be issued for anyone whose financial obligations to the College have not been met.

Signature: _____